New Hampshire Insurance Department

Health Insurance Marketplace Plan Management

2017 QHP Application Process

March 8th, 2016

Agenda (Contents)

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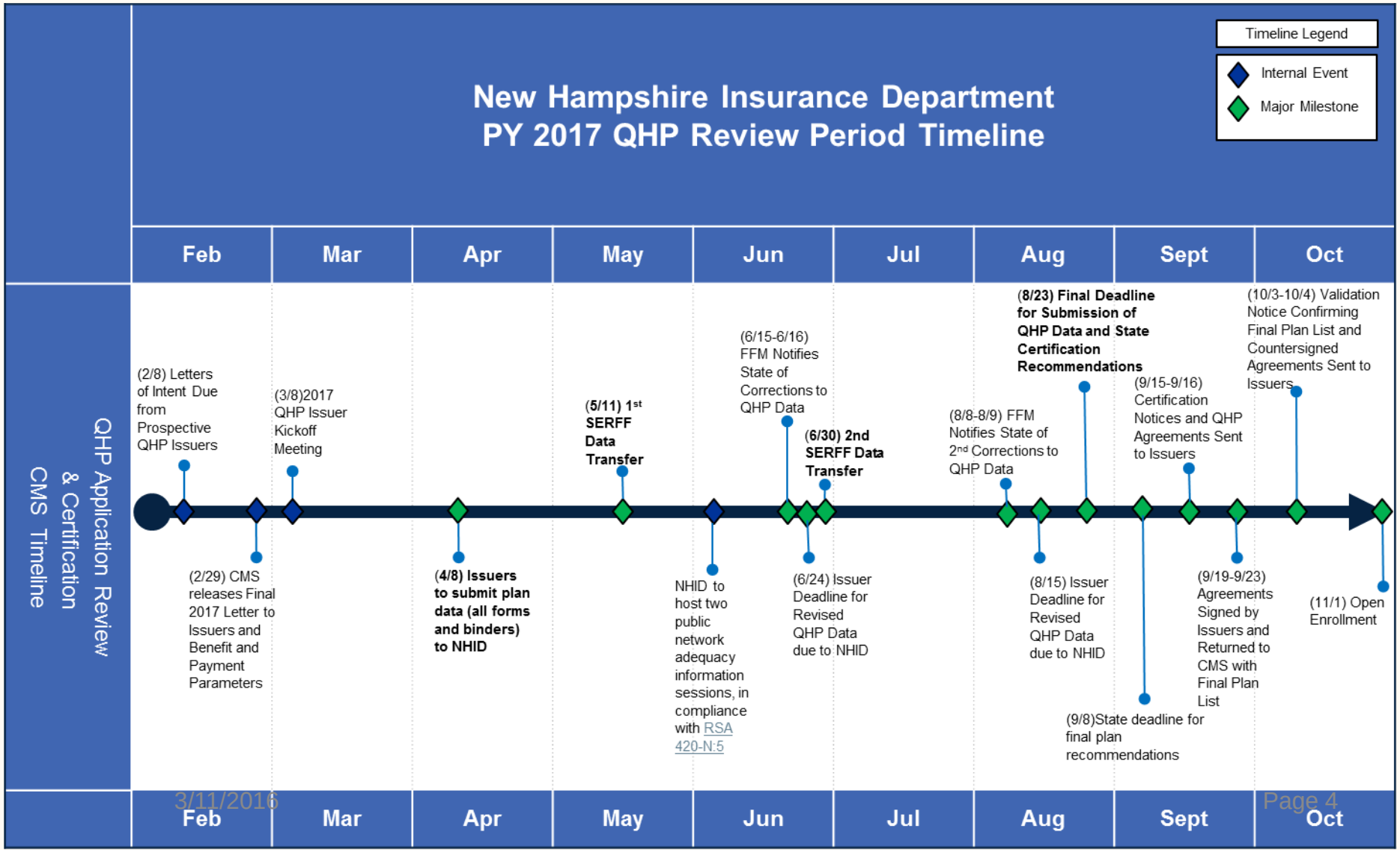
Part 1: Policy Discussion



QHP Guidance and Tools

The Department understands the complexity of the QHP Certification process and as such, the Department has guidance and tools to assist issuers during the QHP submission and review process.

CMS Tools/Guidance include:

- SERFF Industry User Manual
- CMS Instructions for QHP Applications (includes Templates, Supporting Documentation, and Review Tools)
- 2017 Final Letter to Issuers
- 2017 Final Benefit and Payment Parameters

NHIDTools/Guidance include:

- 2017 QHP Certification Issuer Bulletin
- QHP Filing Checklists (Individual, Small Group Medical Plans & Individual/Small Group Stand-Alone Dental Plans)
- Master list of SERFF form and binder documents needed for QHP submission

All NHID tools/guidance will be available on the Department website

QHP Weekly Calls

Much like the 2016 review period, Issuers will have weekly calls with the compliance team and other members of the QHP review team. These calls will be at a set time and day.

- Issuers must submit questions in writing 24 hours in advance of their scheduled weekly conference call. NHID will do their best to have responses prepared in advance of the weekly call.
- Issuers will have an assigned review team much like 2016, and all questions or concerns will be triaged through their review team.
- The Department will post significant updates that arise from questions and responses that pertain to all issuers*

*The Department will not distribute questions/responses containing carrier specific information, product design, rate or other propriety information.

Network Adequacy

NHID will prospectively review adequacy of issuer networks for 2017 plan year based on distance measures from providers.

The State will determine network adequacy through an NHID Network Adequacy Template, created with the goals of:

1. Providing, on a prospective basis, a measure of accessibility offered by issuer networks;

2. Increasing transparency of network data as it relates to service areas and key provider types; and

3. Maintaining consistency of provider network data.

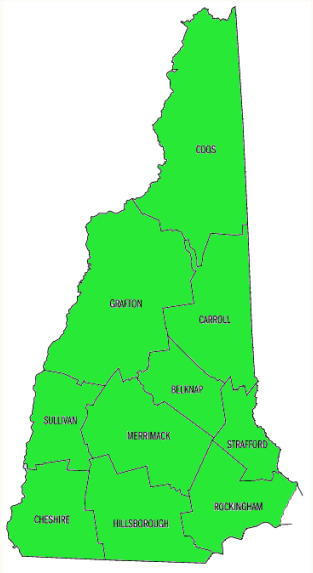
The completion of this template is a State requirement, any remaining federal requirements put in place through new or existing guidance will be considered in addition to the State's review.

NHID Network Adequacy Methodology

NHID will prospectively review adequacy of issuer networks for 2017 plan year based on distance measures from providers. Three scenarios exist for issuers proposing a network:

1

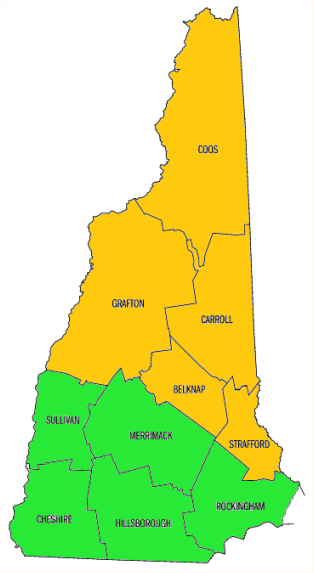
Issuer submits network and has existing QHP membership within the entire proposed service area.



Issuer may use existing QHP enrollment data as population sample

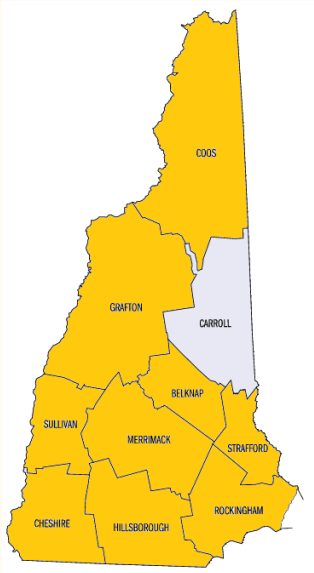
2

Issuer submits network and has existing QHP membership within the state, but not in the entire proposed service area.



3

Issuer submits network without any existing QHP membership within proposed service areas.



Current

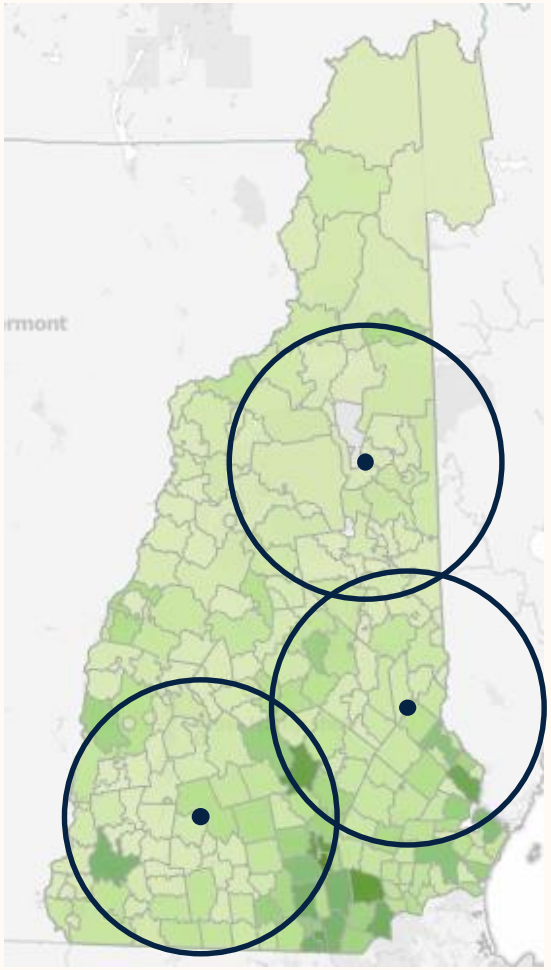
Proposed

Issuer must use proxy population as enrollment data.
Proxy population: Under 65 population by Zip code (data set to be hosted on NHID web site)

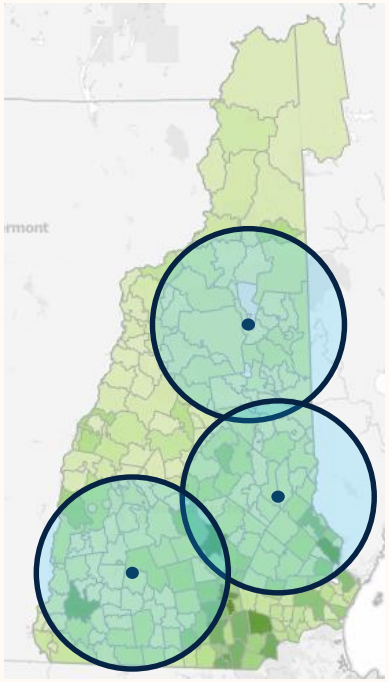
NHID Network Adequacy – Distance Measurement Process

Issuers will be responsible for performing time and distance measures and reporting results

1. Provider location (s) mapped across the State
2. Radius drawn around provider location to cover applicable distance standard (e.g. 45 miles for general surgeons)
3. Under-65 population of all areas within radius are added to the county's "covered" population
4. Covered population compared against the full under-65 population for the county
5. Network adequacy standard is met for that provider type if over 90 percent of the county population is covered



NHID Network Adequacy – Distance Measurement Process Ex.



Zip	Pop.	County	Covered
03218	960	Belknap	Yes
03220	7,430	Belknap	Yes
03225	3,660	Belknap	Yes
03226	1,117	Belknap	Yes
03237	2,254	Belknap	Yes
03246	15,963	Belknap	Yes
03249	7,113	Belknap	Yes
03253	6,219	Belknap	Yes
03256	2,169	Belknap	Yes
03269	2,966	Belknap	Yes
03276	8,324	Belknap	Yes
03809	3,716	Belknap	Yes
03810	1,538	Belknap	No
03837	1,519	Belknap	No

Numerator = Under 65 Population of covered zip codes within county

$$\frac{61{,}891}{63{,}429} = \mathbf{95.3\%}$$

Denominator = Total under 65 population of all zip codes within county

If 90 percent or more of a county's under-65 population lies within the distance standards, the issuer meets network adequacy for that county and may market its plan.

If the covered population is less than 90 percent, the issuer must either expand its network or reduce the proposed service area to exclude counties in which the threshold is not met.

NHID Network Adequacy Template

The NHID Network Adequacy template will include 4 tabs; it is separate from the CMS Template

1 Network Summary

- The template will list the standards for each provider type as defined by state statute
- The Issuer will complete the template for each county in each proposed network
  - Issuer enters issuer name, network name, and network ID for each network
  - For each county in the network, issuer enters whether the specific standard is met

County	Number	Type	Standard	Standard Met?	If Not Met, Enter Justification Code
Belknap	2	Open panel primary care providers	15 miles		
Belknap	1	Pharmacy	15 miles	Yes No	
Belknap	1	Outpatient mental health services	25 miles		

  - The standard is met if 90% or more of the enrolled/proxy population has geographic access coverage based on the applicable standards for that provider type
  - A response of “No” will require justification. Issuers will be able to choose form two common justifications: “No provider exists in the area”, “Provider would not accept offered contract”, or select “Other” and specify the reason

Number	Type	Standard	Standard Met?	If Not Met, Enter Justification Code	If Other, Please Specify
2	Open panel primary care providers	15 miles			
1	Pharmacy	15 miles		1 - No provider exists in the area 2 - Provider would not accept offered contract 3 - Other	
1	Outpatient mental health services	25 miles			

*Issuers must specify whether the standard has been met for all provider types. If additional information is required, the cell will be highlighted YELLOW

NHID Network Adequacy Template – ECP Standards

1 Network Summary (Continued)

CMS Essential Community Providers standards will be included in the Network Summary page as well. Issuers will indicate whether or not they have met the standards for each of the six ECP category types.
For purposes of this template, **an issuer can only say "yes" for "Standard Met?" if there is an existing contract** between the issuer and the applicable ECP category. If a contract has been offered in good faith but was not accepted, the issuer would say "no" and then put the applicable justification code.

Number	Type	Standard	Standard Met?	If Not Met, Enter Justification Code	If Other, Please Specify
1	Essential Community Providers - Family Planning Provider	1 Contracted provider within ECP category			
1	Essential Community Providers - FQHC	1 Contracted provider within ECP category			
1	Essential Community Providers - Hospital	1 Contracted provider within ECP category	Yes No		
1	Essential Community Providers - Indian Health Care Provider	1 Contracted provider within ECP category			
1	Essential Community Providers - Ryan White	1 Contracted provider within ECP category			
1	Essential Community Providers - Other	1 Contracted provider within ECP category			

If the issuer selects "No" for any of the ECP categories, the issuer will be required to provide justification. **NHID may require further documentation and evidence if a standard is not met**

NHID Network Adequacy Template

1 Network Summary (Continued)

- For each network, the issuer will indicate:
  - Market coverage
    - Issuer will choose between “Individual,” “Group” or “Both”
  - QHP/Non-QHP
    - Issuer will choose between “Both” and “Off Exchange”
  - Embedded Dental
    - Issuer will choose between “Yes” and “No”

2 Dental

Only to be completed for Stand Alone Dental Plans as well as Issuers that selected “Yes” for Embedded Dental on any proposed networks

- For each proposed network, issuers will indicate whether or not they meet the standard of 2 open panel general dental care providers in each county
- A response of “No” will require justification. Issuers will be able to choose form two common justifications, or select “Other” and specify the reason the standard is not met

NHID Network Adequacy Template

3 Hospital Contracting

- For each network, issuers will indicate which of the 26 Acute Care Hospitals in NH are in the proposed network
- Select “Yes” or “No” from the dropdown menu for each hospital

Issuer	Network ID	Network	Hospital Name	Address 1	City	State	ZIP Code	County Nam	Hospital in Network?
			Alice Peck Day Memorial Hospital	10 ALICE PEC	LEBANON	NH	03766	Grafton	
			Androscoggin Valley Hospital	59 PAGE HILL	BERLIN	NH	03570	Coos	
			Catholic Medical Center	100 MCGREG	MANCHESTE	NH	03102	Hillsborough	
			Cheshire Medical Center	580 COURT S	KEENE	NH	03431	Cheshire	
			Concord Hospital	250 PLEASAI	CONCORD	NH	03301	Merrimack	
			Cottage Hospital	90 SWIFTWA	WOODSVILLI	NH	03785	Grafton	
			Elliot Hospital	1 ELLIOT WA	MANCHESTE	NH	03103	Hillsborough	
			Exeter Hospital	5 ALUMNI DR	EXETER	NH	03833	Rockingham	
			Franklin Regional Hospital	15 AIKEN AVE	FRANKLIN	NH	03235	Merrimack	
			Frisbie Memorial Hospital	11 WHITEHALI	ROCHESTER	NH	03867	Strafford	
			Huggins Hospital	240 SOUTH M	WOLFEBORO	NH	03894	Carroll	
			Lakes Region General Hospital	80 HIGHLAND	LACONIA	NH	03246	Belknap	
			Littleton Regional Healthcare	600 ST JOHN	LITTLETON	NH	03561	Grafton	
			Mary Hitchcock Memorial Hospital	1 MEDICAL CE	LEBANON	NH	03756	Grafton	
			Memorial Hospital	3073 WHITE M	NORTH CONV	NH	03860	Carroll	
			Monadnock Community Hospital	452 OLD STF	PETERBORO	NH	03458	Hillsborough	
			New London Hospital	273 COUNTY	NEW LONDOI	NH	03257	Merrimack	
			Parkland Medical Center	1 PARKLAND	DERRY	NH	03038	Rockingham	
			Portsmouth Regional Hospital	333 BORTHW	PORTSMOUT	NH	03801	Rockingham	
			Southern NH Medical Center	8 PROSPECT	NASHUA	NH	03060	Hillsborough	
			Speare Memorial Hospital	16 HOSPITAL	PLYMOUTH	NH	03264	Grafton	
			St. Joseph Hospital	172 KINSLEY	NASHUA	NH	03060	Hillsborough	
			Upper Connecticut Valley Hospita	181 CORLISS	COLEBROOK	NH	03576	Coos	
			Valley Regional Hospital	243 ELM STR	CLAREMONT	NH	03743	Sullivan	
			Weeks Medical Center	173 MIDDLE S	LANCASTER	NH	03584	Coos	
			Wentworth-Douglass Hospital	789 CENTRAI	DOVER	NH	03820	Strafford	

NHID Network Adequacy Template

4 SUD Treatment

- For each network, the full list of providers for seven SUD Treatment categories will be shown. The issuer will indicate whether or not each provider is in the network. The seven categories are:
  - Intensive Outpatient Program
  - Partial Hospitalization
  - Residential Services
  - Medication Assisted Treatment (MAT) – Buprenorphine (Suboxone)
  - MAT - Methadone
  - MAT – Naltrexone (Vivitrol)
  - MAT - Other Medication

*If a provider falls under two or more of the service categories listed above, the provider will be listed one time *for each* category it falls under

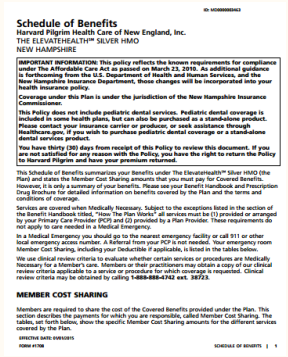
Provider Name	Provider Type	Street Address	City	County	Stat	Zip	Provider in Network?
Addiction Recovery Services	Intensive Outpatient Program	1145 Sagamore Avenue	Portsmouth	Rockingham	NH	03801	
Another Way	Intensive Outpatient Program	46 Bridge Street, Unit 1	Nashua	Hillsborough	NH	03060	
Chemical Dependency Consulta	Intensive Outpatient Program	370 Portsmouth Avenue	Greenland	Rockingham	NH	03840	

Issuer Evaluation of QHP Application

Matching Policy Forms and Plan and Benefit Templates

- Last year NHID and CMS found significant discrepancies between the benefit and cost sharing wording on forms, and the way plans were categorized in the plan and benefit templates
- Issuers must input data into the plan and benefits template accurately and that data *must* match the policy forms
  - Functionality in the plan and benefits template must be used to show whether a benefit has any limits, and any applicable exclusions or benefit explanations
- When plan and benefit templates are updated through the certification process, the plans forms must be updated as well
- Discrepancies will significantly slow down the review process and possibly cause issuers to not be certified in 2017

FORMS



Schedule of Benefits
Harvard Pilgrim Health Care of New England, Inc.
THE ELEVATEHEALTH℠ SILVER HMO
NEW HAMPSHIRE

IMPORTANT INFORMATION: This policy reflects the known requirements for compliance under The Affordable Care Act as passed on March 23, 2010. As additional guidance is forthcoming from the U.S. Department of Health and Human Services, and the New Hampshire Insurance Department, those changes will be incorporated into your health insurance policy.

Coverage under this Plan is under the jurisdiction of the New Hampshire Insurance Commissioner.

This Policy does not include pediatric dental services. Pediatric dental coverage is included in some health plans, but can also be purchased as a stand-alone product. Please contact your insurance carrier or producer, or seek assistance through Healthcare.gov, if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

You have thirty (30) days from receipt of this Policy to review this document. If you are not satisfied for any reason with the Policy, you have the right to return the Policy to Harvard Pilgrim and have your premium returned.

This Schedule of Benefits summarizes your Benefits under The Elevatehealth℠ Silver HMO (the Plan) and states the Member Cost Sharing amounts that you must pay for Covered Benefits. However, it is only a summary of your benefits. Please see your Benefit Handbook and Prescription Drug Brochure for detailed information on benefits covered by the Plan and the terms and conditions of coverage.

Services are covered when Medically Necessary. Subject to the exceptions listed in the section of the Benefit Handbook titled, "How The Plan Works" all services must be (1) provided or arranged by your Primary Care Provider (PCP) and (2) provided by a Plan Provider. These requirements do not apply to care needed in a Medical Emergency.

In a Medical Emergency you should go to the nearest emergency facility or call 911 or other local emergency access number. A Referral from your PCP is not needed. Your emergency room Member Cost Sharing, including your Deductible if applicable, is listed in the tables below.

We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our clinical review criteria applicable to a service or procedure for which coverage is requested. Clinical review criteria may be obtained by calling 1-888-888-4742 ext. 38723.

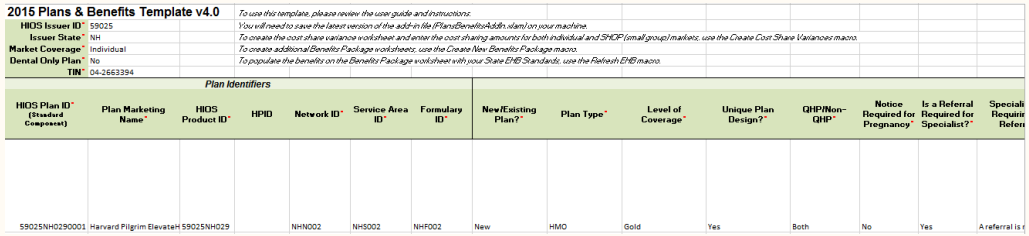
MEMBER COST SHARING

Members are required to share the cost of the Covered Benefits provided under the Plan. This section describes the payments for which you are responsible, called Member Cost Sharing. The tables, set forth below, show the specific Member Cost Sharing amounts for the different services covered by the Plan.

EFFECTIVE DATE: 01/01/2015

FORM #1708 SCHEDULE OF BENEFITS | 1

TEMPLATES



2015 Plans & Benefits Template v4.0 — *To use this template, please review the user guide and instructions.*

HIOS Issuer ID*	59025	*You will need to save the latest version of the add-in file (PlansBenefitsAddIn.xlam) on your machine.*
Issuer State*	NH	*To create the cost share variance worksheet and enter the cost sharing amounts for both individual and SHOP (small group) markets, use the Create Cost Share Variances macro.*
Market Coverage*	Individual	*To create additional Benefits Package worksheets, use the Create New Benefits Package macro.*
Dental Only Plan*	No	*To populate the benefits on the Benefits Package worksheet with your State EHB Standards, use the Refresh EHB macro.*
TIN*	04-2663394	

Plan Identifiers

HIOS Plan ID* (Standard Component)	Plan Marketing Name*	HIOS Product ID*	HPID	Network ID*	Service Area ID*	Formulary ID*	New/Existing Plan?*	Plan Type*	Level of Coverage*	Unique Plan Design?*	QHP/Non-QHP*	Notice Required for Pregnancy*	Is a Referral Required for Specialist?*	Specialt Requirir Referr
59025NH0290001	Harvard Pilgrim ElevateH	59025NH029		NHN002	NHS002	NHF002	New	HMO	Gold	Yes	Both	No	Yes	A referral is r

Issuer Evaluation of QHP Application

Review Tools Requirement

- NHID will require attestations from issuers that all CMS QHP tools have been run and errors resolved prior to submission of data templates
- If issuers receive an “unmet” when running a tool but believe they are still compliant, they must submit the excel tool’s results tab and add an “explanations” column for their justification. Both the attestation form and excel spreadsheet must be uploaded to the Supporting Documents tab in SERFF.

ATTESTATION FOR COMPLIANCE WITH THE QHP REVIEW TOOLS REQUIREMENT PER NEW HAMPSHIRE INSURANCE DEPARTMENT BULLETIN Docket No.: INS-15-XXX-XX

I, the undersigned officer of _____ do hereby attest that:

(NAME OF ENTITY)

I have carefully reviewed the contents of this submission in regards to CMS QHP REVIEW TOOLS requirements contained with the 2017 Plan Year QHP Bulletin Docket No.: INS-15-XXX-XX; have read and understand penalties may be enforced for submission of templates not having met the requirements of the CMS QHP review tools. I have run all applicable CMS review tools, and if any tool results show an unmet requirement, I have uploaded to SERFF the excel tool’s results tab with an added explanations column with my justification explaining why the plans are still in compliance with the federal requirements even though they did not pass the tool review.

_____ _____

(Original Signature of Officer*) (Title of Officer*)

_____ _____

(Printed Name of Officer*) (Date)

* If the individual signing the certification is someone other than the president, vice president, assistant vice president, corporate secretary, assistant corporate secretary, CEO, CFO, COO, general counsel, or an actuary that is also a corporate officer, documentation must be included that shows that this individual has been appointed as an officer of the organization by the Board of Directors.

Provider Transitions

Provider termination for any reason

- A QHP is required to make a good faith effort to provide written notice to enrollees 30 days before termination of their providers seen regularly as well as all PCPs
- CMS expects the issuer to work with the provider or use its claims data system to identify enrollees who see the affected providers
- CMS encourages issuers to notify enrollees of comparable in-network providers, provide information on how to access the plan's continuity of care coverage, and encourage the enrollee to contact the plan with any questions

Provider termination without cause

- A QHP is required to allow an enrollee in "active course of treatment" (includes treatments for mental health and substance use disorders) to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates
- Issuers are responsible for paying the same terms and conditions of the provider contract, including any protections against balance billing, if the provider agrees to provide care

QHP issuers are required to update internal processes and procedures to implement these requirements for PY 2017

Meaningful Difference

Process

- CMS will organize issuer's QHPs into subgroups based on plan type, metal level, child-only plan status and overlapping counties / service areas
- CMS will review each subgroup for at least one material difference in cost sharing, provider network, or covered benefits.

- **Cost Sharing:**
  - Integrated medical and drug maximum out-of-pocket (MOOP)
  - Integrated medical and drug deductible
  - $500 difference in MOOP
  - $250 difference in deductible
  - Multiple in-network tiers
- **Provider Networks:**
  - Different provider network IDs
- **Covered Benefits:**
  - Vary in coverage of one or more benefit displayed on healthcare.gov

Cost Sharing

In line with the anticipated annual update, the permitted annual limitations on cost sharing have increased across all coverage levels—including for cost-sharing reduction plans:

Category	2016		2017	
	Self-Only	Other than Self-Only	Self-Only	Other than Self-Only
Maximum Annual Limit on Cost Sharing	$6,850	$13,700	$7,150	$14,300
Reduced Annual Limit on Cost Sharing for Individuals between 100 and 150% of the Federal Poverty Level (FPL)	$2,250	$4,500	$2,350	$4,700
Reduced Annual Limit on Cost Sharing for Individuals between 150 and 200% of the Federal Poverty Level (FPL)	$2,250	$4,500	$2,350	$4,700
Reduced Annual Limit on Cost Sharing for Individuals between 200 and 250% of the Federal Poverty Level (FPL)	$5,450	$10,900	$5,700	$11,400

Awaiting IRS Guidance on HSA Limits

Standard Plans

- To simplify the consumer plan-selection process, HHS is proposing to establish "standardized options" in the individual market FFEs

- NHID points out Standardized options will **NOT** be possible in New Hampshire:
  - NH law RSA 415:6-s requires that cost sharing for chiropractor and physical therapists services must not exceed the cost sharing for primary care provider services.
  - CMS clarifies in the 2017 Final Benefit and Payment Parameters: ***"issuers must comply with State law, which may mean that issuers in those States will be unable to offer some or all of the standardized options established through this rule-making…"***

	Bronze	Silver	Silver 73% Actuarial Value Variation	Silver 87% Actuarial Value Variation	Silver 94% Actuarial Value Variation	Gold
Actuarial Value (%)	61.88	70.63	73.55	87.47	94.30	79.98
Deductible	$6,650	$3,500	$3,000	$700	$250	$1,250
Annual Limitation on Cost Sharing	$7,150	$7,150	$5,700	$2,000	$1,250	$4,750
Emergency Room Services	50%	$400 (copay applies only after deductible)	$300 (copay applies only after deductible)	$150 (copay applies only after deductible)	$100 (copay applies only after deductible)	$250 (copay applies only after deductible)
Urgent Care	50%	$75 (*)	$75 (*)	$40 (*)	$25 (*)	$65 (*)
Inpatient Hospital Services	50%	20%	20%	20%	5%	20%
Primary Care Visit	$45 (* first 3 visits, then subject to deductible and 50% coinsurance)	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$20 (*)
Specialist Visit	50%	$65 (*)	$65 (*)	$25 (*)	$15 (*)	$50 (*)
Mental Health/ Substance Use Disorder Outpatient Services	$45 (*)	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$20 (*)
Imaging (CT/PET Scans, MRIs)	50%	20%	20%	20%	5%	20%
Rehabilitative Speech Therapy	50%	20%	20%	20%	5%	20%
Rehabilitative OT/PT	50%	20%	20%	20%	5%	20%
Laboratory Services	50%	20%	20%	20%	5%	20%
X-rays	50%	20%	20%	20%	5%	20%
Skilled Nursing Facility	50%	20%	20%	20%	5%	20%
Outpatient Facility Fee	50%	20%	20%	20%	5%	20%
Outpatient Surgery Physician/Surgical	50%	20%	20%	20%	5%	20%
Generic Drugs	$35 (*)	$15 (*)	$10 (*)	$5 (*)	$3 (*)	$10 (*)
Preferred Brand Drugs	35%	$50 (*)	$50 (*)	$25 (*)	$5 (*)	$30 (*)
Non-Preferred Brand Drugs	40%	$100 (*)	$100 (*)	$50 (*)	$10 (*)	$75 (*)
Specialty Drugs	45%	40% (*)	40% (*)	30% (*)	25% (*)	30% (*)

(*) = not subject to the deductible

Prescription Drugs

45 CFR 156.122 requires a health plan providing EHBs to cover at least the greater of (1) one drug in every US Pharmacopeial convention category and class or (2) the same number of prescription drugs in each category and class as the EHB state benchmark plan.

NH 2017 Benchmark

Category	Class	Count
Analgesics	Opioid Analgesics, Long-acting	11
Analgesics	Opioid Analgesics, Short-acting	14
Anti-Addiction/Substance Abuse Treatment Agents	Alcohol Deterrents/Anti-craving	2
Anti-Addiction/Substance Abuse Treatment Agents	Opioid Dependence Treatments	2
Anti-Addiction/Substance Abuse Treatment Agents	Opiod Reversal Agents	1
Anti-Addiction/Substance Abuse Treatment Agents	Smoking Cessation Agents	3

Prescription Drugs

156.122(c) requires health plans to have a process to allow an enrollee to request and gain access to clinically appropriate drugs not otherwise covered by the health plan. The process must include:

- an internal review; federal regulations require the carrier to make a determination and notify the enrollee no later than 72 hours following receipt of the request, however, RSA 420-J:7-b requires that the process not exceed 48 hours),
- an external review,
- the ability to expedite the reviews (must make determination and notify the enrollee no later than 24 hours following receipt of the request).
- In the event that an exception request is granted, the excepted drug(s) are treated as an EHB including counting any cost-sharing towards the plan's annual limitation on cost-sharing.

Clinically Appropriate Drug not on Drug List

Discriminatory Benefit Design and Prescription Drugs

- Outliers will be based on estimated out-of-pocket costs associated with the standard treatment protocols for medical services and drug regimens needed to treat:
  - bipolar disorder,
  - diabetes,
  - HIV,
  - rheumatoid arthritis,
  - schizophrenia.
- CMS will review the availability of drugs and related cost-sharing for: bipolar disorder, breast and prostate cancer, diabetes, hepatitis C, HIV, multiple sclerosis, rheumatoid arthritis and schizophrenia
- CMS will also consider the impact of prescription drug tiering

Average cost for diabetes drug regimen

Flagged outlier cost for diabetes drug regimen

Rate Review

- Starting in 2017, rate increases will be considered at the plan, not the product, level
- Rather than considering the change to the index rate, the rules requires consideration of the average increase for all enrollees (weighted by premium volume), factoring in the impact of premium rating factors

Issuers without any plan rate increases:
- ✓ Unified Rate Review Template (URRT)

Issuers with plan rate increases below the threshold:
- ✓ Unified Rate Review Template (URRT);
- ✓ Actuarial Memorandum.

Issuers with plan rate increases above the threshold:
All parts of the Rate Filing Justification:
- ✓ Unified Rate Review Template (URRT);
- ✓ Written description justifying the rate increase;
- ✓ Actuarial Memorandum.

- **May 25**: CMS will post initial proposed rate change information available for consumers to review on https://ratereview.healthcare.gov (CMS will post information for all single risk pool coverage proposed rate filings not just those subject to review)[1]
- **Nov 1:** All final rates will be posted online

[1] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2016-key-dates-table-2-29-16.pdf

Stand-Alone Dental

All Stand-Alone Dental Plan (SADP) issuers are bound by the same timeline as QHP issuers, included on Slide 4

SADPs shall be filed using the SERFF system, and additional guidance regarding SADP filings can be found in the following documents:

- 2017 Letter to Issuers in the Federally-Facilitated Marketplace;
- NHID 2017 Issuer Bulletin; and
- SADP Small Group and Individual Filing Checklists

SADP Network Adequacy: Access to coverage will be deemed adequate in cases where the issuer offers two open-panel general practice dental providers for each county within the proposed service area.

2017 SADP A/V and MOOP

Plan Type	A/V Level
High	85%
Low	70%

Number of Children	MOOP
1 Child	$350
2 or more	$700

Stand-Alone Dental

Stand-alone dental plans, as offerors of excepted benefits, are not subject to many of the requirements that are applicable to all QHP issuers.

Standard or Tool Applies (* denotes modified standard)	
Essential Health Benefits*	Actuarial Value*
Annual Limits on Cost Sharing*	Licensure
Network Adequacy	Inclusion of ECPs
Non-discrimination	Service Area
Acceptance of Third Party Premium and Cost-sharing Payments	Data Integrity Tool
Rates submission*	Machine Readable* (SADPs must comply with provider directory standards but not drug formulary standards)
Transparency in Coverage Reporting	

Standard or Tool Does Not Apply	
Accreditation	Patient Safety
Quality Reporting and Quality Improvement Strategy	Meaningful Difference
Prescription Drugs	Standardized Options
Cost Sharing Reductions	Out-of-Pocket Cost Comparison Tool

SADP issuers applying for “Off-Exchange Certified” designations must comply with all standards applicable to on-Marketplace plans.

Quality Improvement Strategy Requirements

QIS Definition

- Payment structure that provides increased reimbursement or other market-based incentives for improving health outcomes of plan enrollees. QIS must also include activities related to:
  1. Improving health outcomes;
  2. Preventing hospital readmissions;
  3. Improving patient safety and reducing medical errors;
  4. Promoting wellness and health; and/or
  5. Reducing health and health care disparities.

Who has to participate?

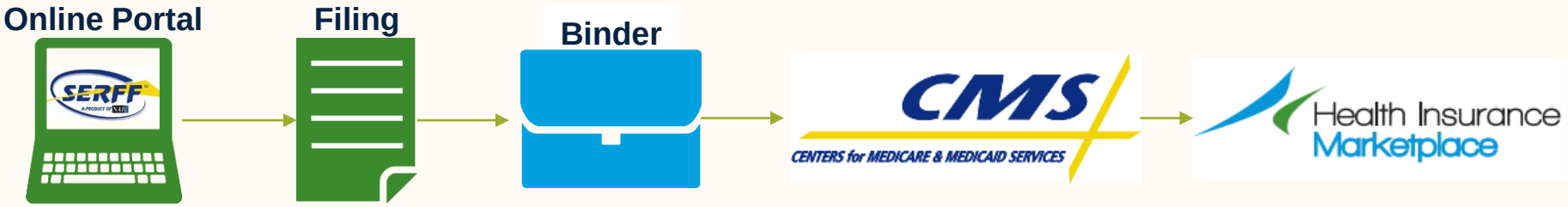
- Issuers covering 500 enrollees that offered marketplace coverage during 2014 and 2015 must implement one or more QIS that covers all of their QHPs; a QIS does not have to address the needs of all enrollees
- Issuers must: submit the QIS Implementation Plan during the 2017 certification process; implement the QIS beginning 1/2017; and submit a Progress Report the following year.
- QIS Guidelines were published 11/2015.

CMS posted the Quality Improvement Strategy: Technical Guidance and User Guide for the 2017 Coverage Year and the Quality Improvement Strategy Implementation Plan and Progress Report form and the issue brief describing these 2017 requirements.

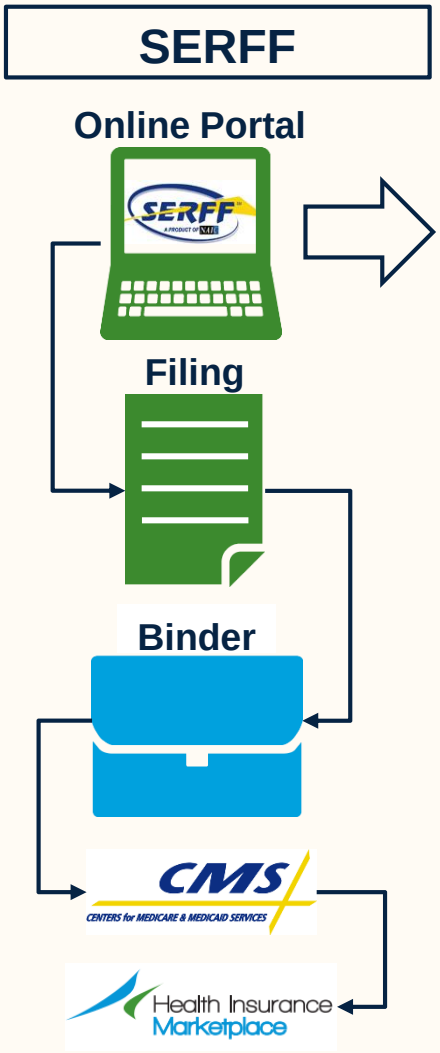
Part 2: SERFF and Filing Submittal

QHP filings to be submitted through the NAIC System for Electronic Rate and Form Filing (SERFF)

Process from SERFF to plan visibility on the Marketplace:



QHP Filing Submission - SERFF

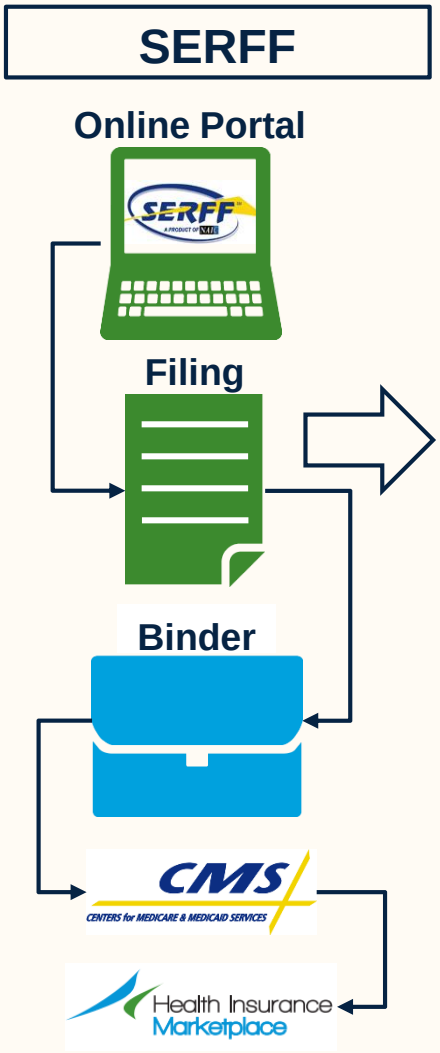


- QHP filings to be submitted through the System for Electronic Rate and Form Filing (SERFF)
- SERFF components include Filings (form/rate) and Binders

Online Portal

- Issuers must have valid SERFF ID and adequate access to submit Form/Rate filings to NHID
- SERFF Plan Management Industry Manual found at https://login.serff.com/Appendix%20II.pdf
- NHID has “retaliatory” fee requirements, meaning that issuer’s state of domicile determines whether the issuer submits a filing fee

QHP Filing Submission - SERFF

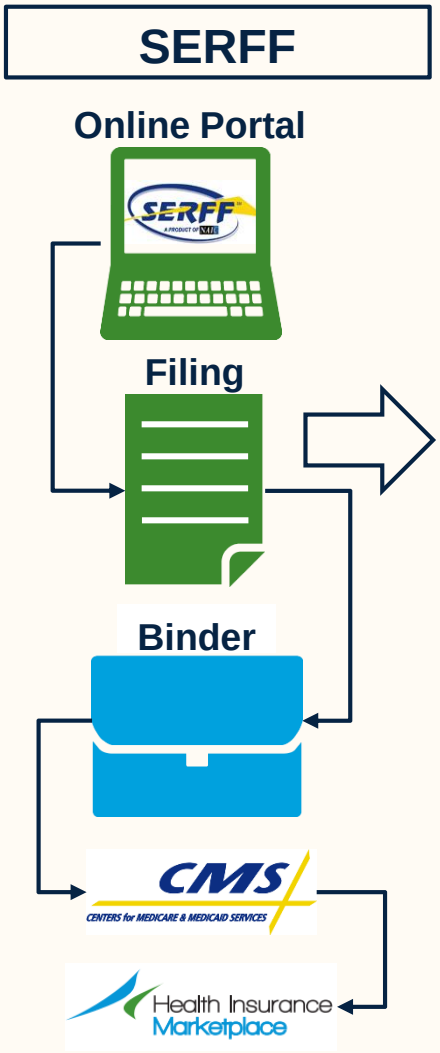


Filing

- Filings are submitted through SERFF
- Instructions to create a filing: https://login.serff.com/Complete%20Industry%20Manual.pdf
- Filings must be submitted as a “Form/Rate” Filing type

Complete Filings
Due: April 8, 2016

QHP Filing Submission - SERFF



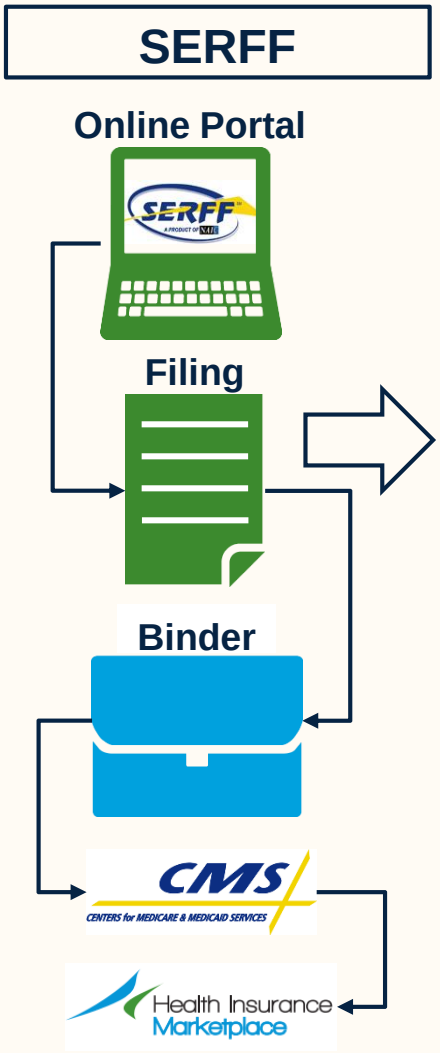
Components of a Form/Rate Filing

Form Schedule Documents

- Policy
- Certificate
- Outline of Coverage
- ID Cards
- Schedule of Benefits
- Summary of Benefits and Coverage

• Application / Enrollment

QHP Filing Submission - SERFF

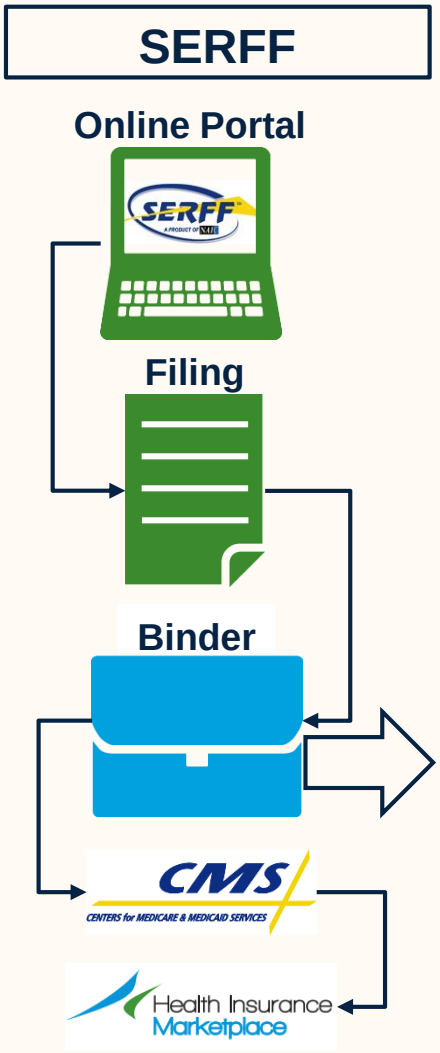


Components of a Form/Rate Filing

Supporting Documentation

- NHID Issuer Checklist
- Compliance Certification
- (Applicable) NHID Filing Checklist
- Certificate of Readability
- Patient Bill of Rights
- Summary Notice of Continuation of Coverage rights
- Managed Care Consumers Guide to External Appeal

QHP Filing Submission - SERFF

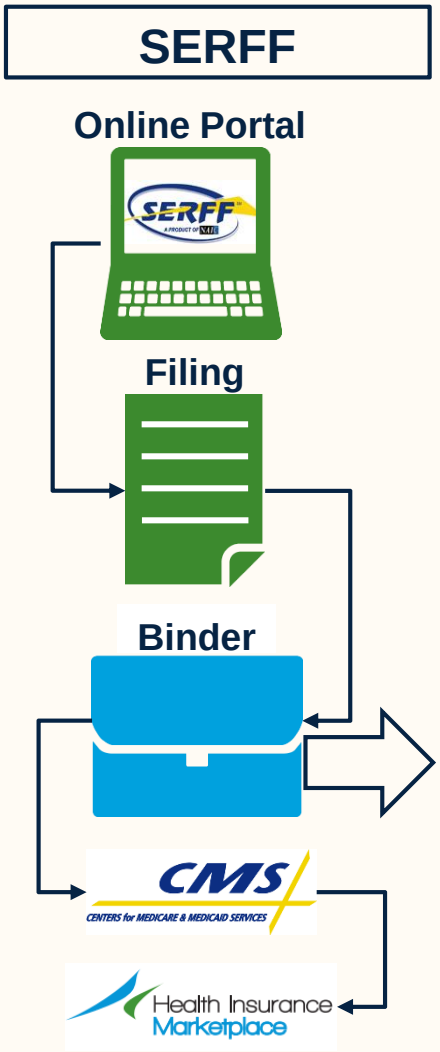


Binder

- Binder contain specific QHP content and hyperlinks data from filings
- Instructions on binders: https://login.serff.com/Appendix%20II.pdf

Final Binders Transferred to FFM: August 23, 2016

QHP Filing Submission - SERFF

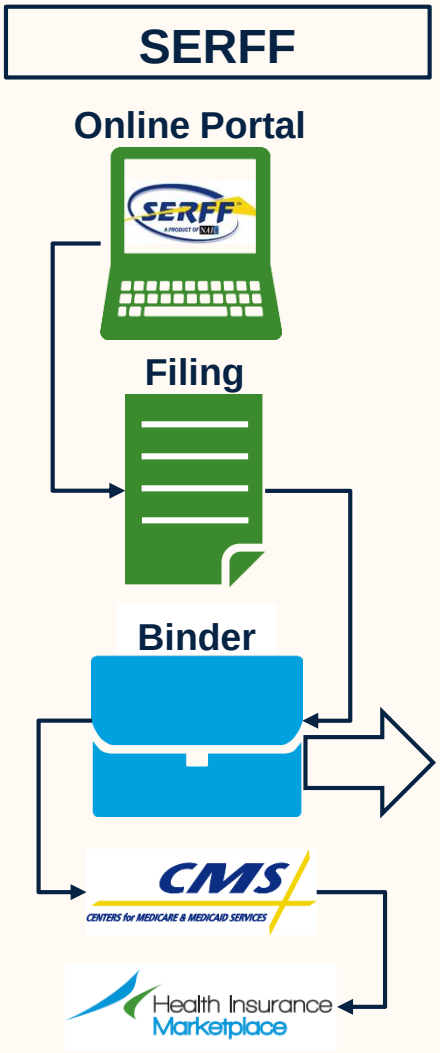


Components of a QHP Binder

Associate Schedule Items

- Issuer links documents from form/rate filing
- Forms queried from filings by the SERFF tracking number
- Forms assigned to specific plans within the binder

QHP Filing Submission - SERFF

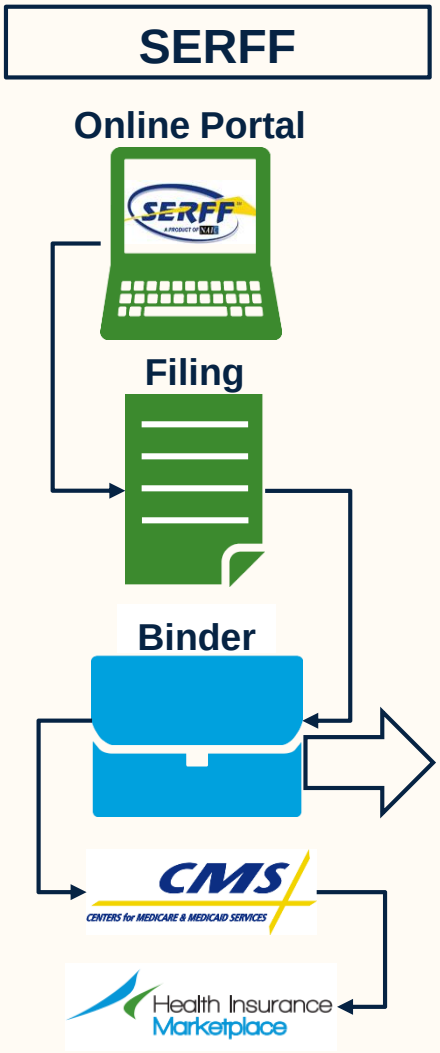


Components of a QHP Binder

QHP Templates

- Plan and Benefits
- Prescription Drug
- Network
- Service Area
- Essential Community Providers/ Network Adequacy
- Rate Data
- Rating Business Rules

QHP Filing Submission - SERFF



Components of a QHP Binder

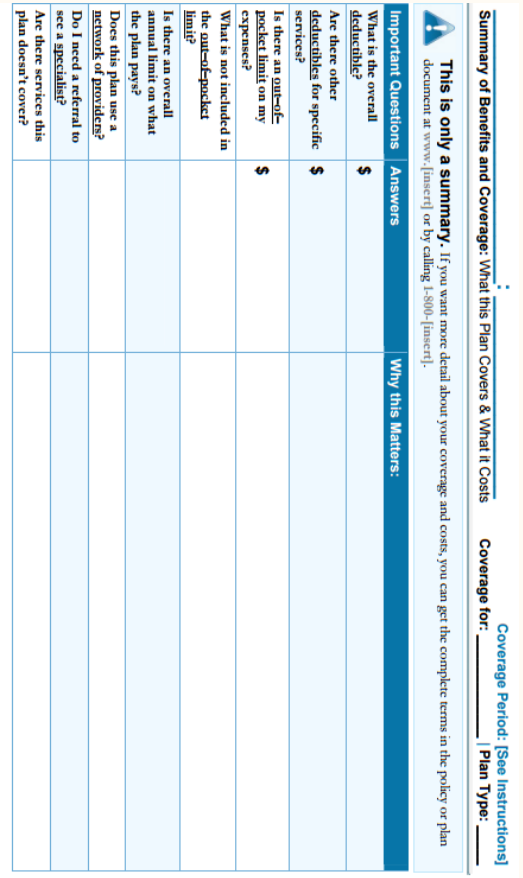
Supporting Documentation

- NHID Network Adequacy Template
- Compliance Plan/Org Chart
- SPM Attestations
- Unified Rate Review
- Actuarial Memorandum
- Plan ID Crosswalk
- Licensure
- Cert. of Good Standing
- Advertising Attestation
- CMS Tools Attestation

Summary of Benefits and Coverage

For Plan Year 2017, New Hampshire would like to clarify the following items related to both Summary of Benefits and Coverage (SBCs) and Schedule of Benefits (SOBs) submissions:

- Must be submitted in the form filing, and not on the binder.
- No variables are allowed.
- The PDF file must be named with the corresponding HIOS Plan ID and variant, and issuers must also associate the schedule item so it links to the correct plan within the binder.
- The form number must be included on the document itself.



Summary of Benefits and Coverage: What this Plan Covers & What it Costs — **Coverage for:** _____ | **Plan Type:** ____ — Coverage Period: [See Instructions]

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.[insert] or by calling 1-800-[insert].

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$	
Are there other deductibles for specific services?	$	
Is there an out-of-pocket limit on my expenses?	$	
What is not included in the out-of-pocket limit?		
Is there an overall annual limit on what the plan pays?		
Does this plan use a network of providers?		
Do I need a referral to see a specialist?		
Are there services this plan doesn't cover?		

Further details on NH requirements for SBCs and schedules can be found in the NHID filing checklists.

Advertising

The ACA and subsequent Federal regulations grant the Department the power to review marketing materials, including advertisements, and ensure that materials are not false, misleading or discriminatory. Additionally, the Department will review materials to ensure that that marketing practices or benefit designs will not have the effect of discouraging the enrollment of individuals with significant health needs in QHPs.

- NHID will require issuers to file advertisements prior to use
- Issuers must submit advertisements in SERFF in the filing mode of “information only” with the filing type marked as “Advertising.”
- All forms must have a form number in the lower left hand corner.
- In addition to the informational filing, issuers shall submit an attestation in the supporting documentation tab in SERFF stating that all advertising materials are in compliance with applicable state and federal regulations, including the standards set forth in RSA 420-B:12, I.
- All advertising that includes cost sharing and benefit descriptions must be filed for review and approval by the Department. Carriers should carefully consider the use of benefit and cost sharing marketing materials prior to submission.
- Advertising includes webpages specific to NH and must also comply with NHCAR Part Ins 401.03 (a) (1).
- All issuers should be prepared to participate in a full review of all filed materials, and are reminded that advertisements are subject to a market conduct review if issues arise after use. Issuers are urged to consult the NHID guidance entitled 2015 QHP Certification: Guidance on the Filing of Advertising Materials (Bulletin INS-14-015) for additional information.

Helpful Filing Tips

State licensure:

- Issuer licenses are renewed on June 15 of each year-currently during the QHP review period. In order to receive a recommendation for certification, the issuer must re-apply for a license in the State for the next year and provide proof of this application to the Department.
- State license must be provided for the correct company for the filing (HMO product must have HMO license, etc.)
- Issuers are reminded that they must submit to the Department proof of licensure for all subcontractors or third party entities performing services on their behalf.

NHID Filing Check Lists

- SADP – Individual and SHOP
- Medical – Individual and SHOP
- Issuers must submit the applicable check list with filings, these check lists are currently under review, with updated versions expected to be posted soon to http://www.nh.gov/insurance/lah/

SERFF, QHP Templates, Supporting Documentation

- In SERFF, select the applicable Type of Insurance (TOI) to the plans submitted (HMO, PPO, POS).
- When associating schedule items in SERFF, the Standard Component ID must be entered exactly as generated by HIOS.
- Both On- and Off-Exchange plans must be contained in a binder and be submitted through SERFF.
- Advertisements must be submitted for approval within its own SERFF filing (Filing Type: Advertisement).
- Remember to set your SERFF messages to accept binder notifications.
- Changes to forms may require changes to binders and vice versa.

New Hampshire Insurance Department Contacts

NHID Division	Contact	Email
Executive Office	Roger Sevigny	Roger.Sevigny@ins.nh.gov
Executive Office	Alexander Feldvebel	Alexander.Feldvebel@ins.nh.gov
Operations/Health Reform	Alain Couture	Alain.Couture@ins.nh.gov
Legal & Enforcement	Jennifer Patterson	Jennifer.Patterson@ins.nh.gov
LAH Director	Michael Wilkey	Michael.Wilkey@ins.nh.gov
Compliance	Sonja Barker	Sonja.Barker@ins.nh.gov
Compliance	Diana Lavoie	Diana.Lavoie@ins.nh.gov
Compliance	Tom Weston	Thomas.Weston@ins.nh.gov
Compliance	Ingrid Marsh	Ingrid.Marsh@ins.nh.gov
Compliance	David Schechtman	David.Schechtman@ins.nh.gov
LAH Actuarial	David Sky	David.Sky@ins.nh.gov
Consumer Services	Keith Nyhan	Keith.Nyhan@ins.nh.gov
PCG	Margot Thistle	Mthistle@pcgus.com
PCG	Lisa Kaplan Howe	Lkaplanhowe@pcgus.com
PCG	Blair Kennedy	Bkennedy@pcgus.com
PCG	Bobby Riso	Rriso@pcgus.com

Thank You

Contact Information

New Hampshire Insurance Department
21 South Fruit Street, Suite #14
Concord, NH 03301
requests@ins.nh.gov
Phone: (603) 271-2261
Fax: (603) 271-1406
TTY/TDD: 1 (800) 735-2964

www.nh.gov/insurance

Health Insurance Marketplace Plan Management